S. No. 2
0M—2-43
v. 5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 20 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18030

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1023

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 73 days (Specify whether
In this community 6 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0-00
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3625 Flad 7
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME EUGENE MAX WALTER DOERLICH

3. (b) If veteran, name war no
3. (c) Social Security No. -

4. Sex male 0
5. Color or race white
6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased 3 (Month) 27 (Day) 1892 (Year)

8. AGE: Years 54 Months 1 Days 13 If less than one day hr. min.

9. Birthplace (City, town, or county) Germany 4 (State or foreign country)
10. Usual occupation mechanic
11. Industry or business

FATHER
12. Name Edmund Doerlich
13. Birthplace (City, town, or county) Denmark 4 (State or foreign country)

MOTHER
14. Maiden name Anna Dideck
15. Birthplace (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Koch Hospital, Koch, Mo.
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 5-13-46 (Month) (Day) (Year)
(c) Place: burial or cremation Mo. Crematory
18. (a) Signature of funeral director Witt Bros. L & N.W.
(b) Address 2929 S. Jefferson Av.
19. (a) 5-13-46 (Date received local registrar) (b) E. G. McGavran MD (Registrar's signature) 98

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10 year 1946 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from 2-26- 1946, to 5-10 1946; that I last saw him alive on 5-10- 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	6 mo. (?)
Due to: Thoracoplasty	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Confirms above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Bernard Friedman (M. D. or other) MD
Address Robert Koch Hospital Date signed 5-11-46

(Licensed Embalmer's Statement on Reverse Side)

JUN 6 1946

JUN 3 1946

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....Edgar F. Witt.....

Licensed Embalmer No.....2117.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

— If this body is not embalmed, fact should be so stated above.